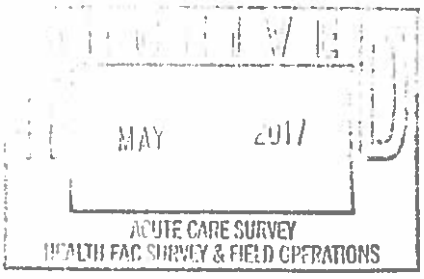
Newark Beth Israel Medical Center
Children's Hospital of New Jersey
Barnabas Health

DARRELL K TERRY, SR., MHA, MPH, FACHE
Interim President and Chief Executive Officer
Newark Beth Israel Medical Center
Children's Hospital of New Jersey

BARRY H. OSTROWSKY
President and Chief Executive Officer
Barnabas Health

May 19, 2017



Carrie Willis, RN,
Health Care Services Evaluator Nurse
Department of Health, Assessment and Survey
120 South Stockton Street, Lower Level
Trenton, New Jersey 08625

Dear Carrie:

Enclosed please find Newark Beth Israel Medical Center's written plan of correction regarding the complaint visit on February 16, 2017. I submitted this corrective action plan via email on May, 19, 2017 and am submitting the hard copy via mail today.

Should you have any questions or concerns related to this matter, please feel free to contact me directly at 973-926-6387.

Sincerely,

Pamela Micchelli, RN, MA
Assistant Vice President, Accreditation and Licensure

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	10709	A. BUILDING: _____ B. WING _____	C 02/16/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NEWARK BETH ISRAEL MEDICAL CENTER	201 LYONS AVE NEWARK, NJ 07112

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 000	8:43G INITIAL COMMENTS A complaint investigation was completed on February 16, 2017. The facility is not in compliance with the requirements of N.J.A.C. Title 8 Chapter 43-G Hospital Licensing Standards for Complaint Investigations: C# NJ00096671.	D 000		
D 624	8:43G-5.2(g) ADMIN & HOSP-WIDE SVCS: POL & PROCEDURES The hospital shall develop and implement a complaint procedure for patients, families, and other visitors. The procedure shall include, at least, a system for receiving complaints, a specified response time, assurance that complaints are referred appropriately for review, development of resolutions, and follow-up action. This REQUIREMENT is not met as evidenced by: Based on review of facility policy and procedure, review of facility document, and staff interview, it was determined that the facility failed to implement its complaint and grievance procedures. Findings include: Reference: Facility Policy titled, 'Patient Complaint and Grievance Management Process' states under the heading "Procedure: 1. Grievances: a. All grievances will be forwarded to	D 624		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: President & CEO — TITLE — (X6) DATE: May 19, 2017

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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D 624	Continued From page 1	D 624		

the Patient Satisfaction/Experience Department, where they will be [first bullet] entered into the electronic database (), [second bullet] acknowledged via phone call, e-mail, letter or conversation with the complainant as soon as possible but not to exceed 72 hours. ... c. Responsible manager/director will perform the investigation and establish an appropriate action plan and patient response. Investigations and responses are to be completed as soon as possible but will not exceed 7 business days except when extenuating circumstances exist. If investigation or corrective action cannot be completed within seven business days, due to extenuating circumstances; then the complainant will be contacted by the Patient Experience Department and advised of the status of the investigation and anticipated completion date. d. Written communication will be issued to the complainant when the investigation is complete. The communication will include a summary of the findings and actions taken by the facility (when applicable) to resolve the grievance. Issuance of this letter will occur within 30 days. ..."

1. On 2/16/17, interview with Staff #7 revealed that he/she did get a phone call from a family member of Patient #1 with an alleged complaint but was unable to provide specific dates and times of the alleged occurrences.

a. Staff #7 revealed that the incident was not reported to the facility staff while the patient was admitted in the facility.

(i) The facility was unaware that the alleged event occurred until after both patients were discharged to home.

(ii) There was no record of either patient

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D 624	Continued From page 2 complaining to the staff about an incident occurring until after the patients were discharged. b. There was no evidence of communication with the complainant, in writing or otherwise, regarding the investigation of the grievance, the results of the grievance investigation process, or the date of completion. c. Staff #7 failed to forward or log in the complaint per facility policy. d. The facility failed to follow its complaint/grievance policy. 2. On 2/16/17 at 1:39 PM, Staff # 2 confirmed that the patient grievance was never logged into the electronic database and there was no evidence that letters were sent by the facility.	D 624		
D3756	8:43G-17.1(d) NURSE STAFFING Patient care assignments shall be made on an individual basis by a registered professional nurse and reflect staff competence, skill, and aptitude and patient needs. This REQUIREMENT is not met as evidenced by: Based on staff interviews and review of facility policy and procedure, it was determined that the facility failed to ensure patient care assignments are made on an individual basis and reflect the patient needs. Findings include:	D3756		

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D3756	Continued From page 3 Reference: Facility Nursing Staffing Standards policy and procedures, states, "Purpose: To ensure adequate numbers of qualified professional and support staff in order to provide appropriate patietn care. Policy: Clinical appropriate staff to patient ratios is maintained. These levels are dependant on census and acuity, and are adjusted accordingly. ..." 1. On 2/16/17 at 10:30 AM, a request was made for the patient care assignment sheets for the Children's Crises Intervention Services Unit (CCIS) unit for the dates of 12/20/15 and 12/22/15. a. The facility failed to provide patient care assignment sheets to show evidence of each patients acuity and individual need. 2. Staff #1 confirmed the above findings.	D3756		
D5907	8:43G-26.2(a)(2) PSYCHIATRY: POLICIES & PROCEDURES Policies and procedures of the psychiatry service shall include at least the following: Safety and security precautions for the prevention of suicide, assault, elopement, and patient injury. This REQUIREMENT is not met as evidenced by: Based on a review of a medical record, staff interview and review of facility policy and procedures, it was determined that the facility has a written policy and procedure for safety and	D5907		

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D5907	Continued From page 4 security precautions for the prevention of patient assault that was not implemented. Findings include: Reference: Facility policy titled, 'Safety and Security Precautions', indicates that "Purpose: To provide patients, visitors and staff with a safe and protected environment." Under the title, "Protocols: Every 15-Minute (q15) Check, Patients are observed at least every 15 minutes and remain on this precaution throughout hospitalization. All patients shall be placed on every 15-minute checks on admission (unless a more restrictive precaution is ordered by the physician.). ..." 1. Review of Medical Record #1 revealed that facility staff failed to monitor the patient every 15 minutes in accordance with facility policy. These dates are inclusive of, but not limited to the following: a. On 12/17/15, documented evidence revealed that the patient was monitored by staff at 01:27 and again at 01:45, eighteen (18) minutes later. b. On 12/17/15, documented evidence revealed that the patient was monitored by staff at 19:22 and again at 19:43, twenty-one (21) minutes later. c. On 12/17/15, documented evidence revealed that the patient was monitored by staff at 20:46 and again at 21:11, twenty-five (25) minutes later. d. On 12/17/15, documented evidence revealed that the patient was monitored by staff at 22:50 and again at 23:14, twenty-four (24) minutes later.	D5907		

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D5907	Continued From page 5	D5907		

e. On 12/18/15, documented evidence revealed that the patient was monitored by staff at 00:49 and again at 01:15, twenty-six (26) minutes later.

f. On 12/18/15, documented evidence revealed that the patient was monitored by staff at 01:34 and again at 02:00, twenty-six (26) minutes later.

g. On 12/18/15, documented evidence revealed that the patient was monitored by staff at 04:51 and again at 05:12, twenty-one (21) minutes later.

h. On 12/18/15, documented evidence revealed that the patient was monitored by staff at 06:18 and again at 06:42, twenty-four (24) minutes later.

i. On 12/18/15, documented evidence revealed that the patient was monitored by staff at 06:46 and again at 07:15, twenty-nine (29) minutes later.

j. On 12/22/15, documented evidence revealed that the patient was monitored by staff at 00:04 and again at 00:30, twenty-six (26) minutes later.

k. On 12/22/15, documented evidence revealed that the patient was monitored by staff at 00:49 and again at 01:11, twenty-two (22) minutes later.

l. On 12/22/15, documented evidence revealed that the patient was monitored by staff at 01:47 and again at 02:15, twenty-eight (28) minutes later.

m. On 12/22/15, documented evidence revealed that the patient was monitored by staff at 02:47 and again at 03:08, twenty-one (21) minutes later.

n. On 12/22/15, documented evidence revealed

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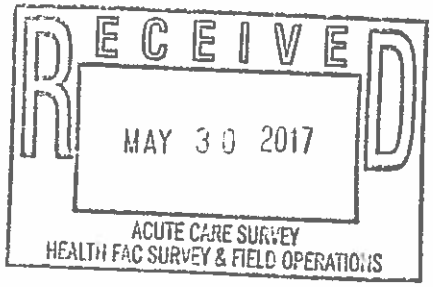
D5907	Continued From page 6 that the patient was monitored by staff at 04:01 and again at 04:28, twenty-seven (27) minutes later. o. On 12/22/15, documented evidence revealed that the patient was monitored by staff at 04:46 and again at 05:06, twenty (20) minutes later. 2. Interview with Staff #7 on 2/16/17 at 10:30 AM confirmed that every patient is placed on a Q (every) 15 minute round check and documentation is completed by the assigned staff.	D5907		

Newark Beth Israel Medical Center
201 Lyons Avenue, Newark, NJ 07112
Provider Number: 10709

Complaint Survey Date: February 16, 2017
Complaint Number 00096671

ID Prefix Tag	DEFICIENCY	CORRECTIVE ACTION	DATE OF COMPLETION
D624	**8:43G-5.2(g) ADMIN & HOSP-WIDE SVCS: POL & PROCEDURES D 624** The hospital shall develop and implement a complaint procedure for patients, families, and other visitors. The procedure shall include, at least, a system for receiving complaints, a specified response time, assurance that complaints are referred appropriately for review, development of resolutions, and follow-up action. This REQUIREMENT is not met as evidenced by: Based on review of facility policy and procedure, review of facility document, and staff interview, it was determined that the facility failed to implement its complaint and grievance procedures. Findings include: Reference: Facility Policy titled, 'Patient Complaint and Grievance Management Process' states under the heading "Procedure: 1. Grievances: a. All grievances will be forwarded to the Patient Satisfaction/Experience Department, where they will be [first bullet] entered into the electronic database (), [second bullet] acknowledged via phone call, e-mail, letter or conversation with the complainant as soon as possible but not to exceed 72 hours.		

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	...c. Responsible manager/director will perform the investigation and establish an appropriate action plan and patient response. Investigations and responses are to be completed as soon as , possible but will not exceed 7 business days except when extenuating circumstances exist. If investigation or corrective action cannot be completed within seven business days, due to extenuating circumstances; then the complainant will be contacted by the Patient Experience Department and advised of the status of the investigation and anticipated completion date. d. Written communication will be issued to the complainant when the investigation is complete. The communication will include a summary of the findings and actions taken by the facility (when applicable) to resolve the grievance. Issuance of this letter will occur within 30 days. ..." 1. On 2/16/17, interview with Staff #7 revealed that he/she did get a phone call from a family member of Patient #1 with an alleged complaint but was unable to provide specific dates and times of the alleged occurrences. a. Staff #7 revealed that the incident was not reported to the facility staff while the patient was admitted in the facility. (i) The facility was unaware that the alleged event occurred until after both patients were discharged to home. (ii) There was no record of either patient	The following has been completed to bring the organization into compliance with the regulations: ➢ Whenever a patient complaint is received and not resolved at the time of the complaint and it is of a serious nature, the staff member and manager will ensure that the complaint is reported to the Patient Experience Department. ➢ The Patient Experience Department will log the complaint into the data base as per policy and initiate the initial letter informing the complainant, monitor the investigation and complete the follow up as per the policy. ➢ Staff education in the form of a FACT sheet detailing the Complaint and Grievance Process was developed and distributed to each staff member including the physicians. The staff member who originally received the complaint could not be identified for counseling session. o The FACT sheet reviewed the requirement for all complaints of a serious nature and grievances must be forwarded as soon as possible to the Patient Experience Department including allegations of patient assault for example. ➢ The process shall be monitored on an ongoing basis by the Behavioral Health leadership including the AVP and Director of the department through active questioning of the staff at morning huddle to ascertain whether any patient complaints have been lodged and whether the Patient experience Department was notified in a timely	Ongoing Ongoing Target completion date: June 15, 2017 May 22, 2017 and ongoing

ID Prefix Tag	DEFICIENCY	CORRECTIVE ACTION	DATE OF COMPLETION
	complaining to the staff about an incident occurring until after the patients were discharged. b. There was no evidence of communication with the complainant, in writing or otherwise, regarding the investigation of the grievance, the results of the grievance investigation process, or the date of completion. c. Staff #7 failed to forward or log in the complaint per facility policy. d. The facility failed to follow its complaint/grievance policy. 2. On 2/16/17 at 1:39 PM, Staff # 2 confirmed that the patient grievance was never logged into the electronic database and there was no evidence that letters were sent by the facility.	manner. ➢ Beginning in June of 2017, the Organization is implementing a new electronic reporting format called VERGE. This platform allows for the immediate logging of complaints and grievances at the point of service. The database is automatically filled and sends out messages to the appropriate parties for follow up. Patient Experience will follow the process once received. ➢ This platform allows for the organization to run department specific reports for compliance. The management team of the unit will be responsible for reconciling the huddle reports of unresolved/serious complaints ➢ The unit will perform monitoring of complaints process for four months and report data at the Performance Improvement Committee. Target goal for reconciliation of complaints /reporting of complaints is a 95% threshold. ➢ Any staff person identified as non-compliant will be counseled immediately	Target date: June 15, 2017 for full implementation Target date: June 15, 2017 and then ongoing Target start date: June 15, 2017 Ongoing
03756 8:43G-17.	**03756 8:43G-17.1(d) NURSE STAFFING** Patient Care assignments shall be made on an individual basis by a registered professional nurse and reflect staff competence, skill, and aptitude and patient needs. This REQUIREMENT is not met as evidenced by: Based on staff interviews and review of facility policy and procedure, it was	The following has been completed to bring the organization into compliance with the regulations: ➢ The patient care assignment sheets evidencing acuity and patient individual needs were reviewed and no changes made. The requested documents were missing the day of survey. ➢ The process for unit Patient Care Assignment	Completed : May 12, 2017 Completed : May 12, 2017

ID Prefix Tag	DEFICIENCY	CORRECTIVE ACTION	DATE OF COMPLETION
	determined that the facility failed to ensure patient care assignments are made on an individual basis and reflect the patient needs. Findings include: Reference: Facility Nursing Staffing Standards policy and procedures, states, "Purpose: To ensure adequate numbers of qualified professional and support staff in order to provide appropriate patient care. Policy: Clinical appropriate staff to patient ratios is maintained. These levels are dependent on census and acuity, and are adjusted accordingly...." 1. On 2116/17 at 10:30 AM, a request was made for the patient care assignment sheets for the Children's Crises Intervention Services Unit (CCIS) unit for the dates of 12120115 and 12/22115. a. The facility failed to provide patient care assignment sheets to show evidence of each patient's acuity and individual need. 2. Staff #1 confirmed the above findings.	management was reviewed and revised. ➢ The revision included the following steps; o Each day the patient care assignments are entered into the binder located in the manager's office. o The action is checked off on the daily login sheet. o The manager will be responsible for scanning the completed patient care assignment sheets into an electronic file. These assignments then will be available for review by regulatory bodies for example. o The paper copies will be stored for 3 months and then discarded. The electronic copies will be maintained for10 years or more. ➢ Initial monitoring performed by the AVP of Behavioral Health services/or designee will be performed monthly to ensure that every day for four months there is an assignment sheet. ➢ The AVP or designee will periodically check the electronic folder to ensure that there is an assignment for each day of the selected month. This monitoring will be added to the metrics currently identified for performance Improvement reporting and reported at the scheduled time.	Begin May 22, 2017 and ongoing Begin June 1, 2017 for 4 months October 1, 2017 and ongoing
05907 8:43G-26.2(a)(2)	**8:43G-26.2(a)(2) PSYCHIATRY: POLICIES & PROCEDURES** Policies and procedures of the psychiatry service shall include at least the following: Safety and security precautions for the prevention of suicide, assault, elopement, and patient injury.		

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	This REQUIREMENT is not met as evidenced by: Based on a review of a medical record, staff interview and review of facility policy and procedures, it was determined that the facility has a written policy and procedure for safety and security precautions for the prevention of patient assault that was not implemented. Findings include: Reference: Facility policy titled, 'Safety and Security Precautions', indicates that "Purpose: To provide patients, visitors and staff with a safe and protected environment." Under the title, "Protocols: Every 15-Minute (q15) Check, Patients are observed at least every 15 minutes and remain on this precaution throughout hospitalization. All patients shall be placed on every 15-minute checks on admission (unless a more restrictive precaution is ordered by the physician.). ..." 1. Review of Medical Record #1 revealed that facility staff failed to monitor the patient every 15 minutes in accordance with facility policy. These dates are inclusive of, but not limited to the following: a. On 12117/15, documented evidence revealed that the patient was monitored by staff at 01:27 and again at 01:45, eighteen (18) minutes later.	The following has been completed to bring the organization into compliance with the regulations: ➢ The policy was reviewed and no revision proposed. ➢ Investigation revealed that there is a delay often in the documenting in the electronic record and the staff may not have corrected the time of actual checking resulting in 15 incidents where the times documented did not reflect the performance of the checks every 15 minutes. ➢ The process for documenting the every 15 checks was modified to include a paper worksheet where the times for the every 15 minute checks would be documented. The hand written times would then be transcribed into the electronic medical record by the person performing the checks. ➢ Staff to be educated at the daily huddles. ➢ The paper documentation from will be placed in the manager mailbox for use in the monitoring process for compliance to the requirement. ➢ For four months, the nursing director or designee will monthly reconcile the paper documentation with the transcribed documentation of every 15 minute checks for 1 shift for 30 patients. The shift, staff and patients will be randomly selected.	Completed : May 12, 2017 Completed : May 12, 2017 Completed : May 12, 2017 Target date for completion: June 1, 2017 Target date for completion: June 1, 2017 and ongoing Begin June 1, 2017 for 4 months

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	b. On 12117/15, documented evidence revealed that the patient was monitored by staff at 19:22 and again at 19:43, twenty-one (21) minutes later. c. On 12117/15, documented evidence revealed that the patient was monitored by staff at 20:46 and again at 21:11, twenty-five (25) minutes later. d. On 12/17/15, documented evidence revealed that the patient was monitored by staff at 22:50 and again at 23:14, twenty-four (24) minutes later. e. On 12118/15, documented evidence revealed that the patient was monitored by staff at 00:49 and again at 01:15, twenty-six (26) minutes later. f. On 12/18/15, documented evidence revealed that the patient was monitored by staff at 01:34 and again at 02:00, twenty-six (26) minutes later. g. On 12/18/15, documented evidence revealed that the patient was monitored by staff at 04:51 and again at 05:12, twenty-one (21) minutes later. h. On 12118/15, documented evidence revealed that the patient was monitored by staff at 06:18 and again at 06:42, twenty-four (24) minutes later. i. On 12118/15, documented evidence revealed that the patient was monitored by	➢ Any staff member found to be non-complaint with the documentation of and performance of every 15 minute checks will immediately be counseled by a member of the management team. ➢ The reconciliation process will be added to the unit performance Improvement metrics and be reported at the scheduled time to the performance Improvement committee.	Begin June 1, 2017 and ongoing Ongoing

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	staff at 06:46 and again at 07:15, twenty-nine (29) minutes later. j. On 12/22/15, documented evidence revealed that the patient was monitored by staff at 00:04 and again at 00:30, twenty-six (26) minutes later. k. On 12122115, documented evidence revealed that the patient was monitored by staff at 00:49 and again at 01:11, twenty-two (22) minutes later. I. On 12/22115, documented evidence revealed that the patient was monitored by staff at 01:47 and again at 02:15, twenty-eight (28) minutes later. m. On 12/22/15, documented evidence revealed that the patient was monitored by staff at 02:47 and again at 03:08, twenty-one (21) minutes later n. On 12122115, documented evidence revealed that the patient was monitored by staff at 04:01 and again at 04:28, twenty-seven (27) minutes later. o. On 12122/15, documented evidence revealed that the-patient was monitored by staff at 04:46 and again at 05:06, twenty (20) minutes later. 2. Interview with Staff #7 on 2/16/17 at 10:30 AM confirmed that every patient is placed on a Q (every) 15 minute round check and documentation is completed by		

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	the assigned staff.		

State of New Jersey
DEPARTMENT OF HEALTH
PO BOX 367
TRENTON, N.J. 08625-0367

www.nj.gov/health

CHRIS CHRISTIE
Governor

KIM GUADAGNO
Lt Governor

CATHLEEN D. BENNETT
Commissioner

Received 5/10/2017

May 9, 2017

Darrell Terry
President and Chief Executive Officer
Newark Beth Israel Medical Center
201 Lyons Ave
Newark, NJ 07112

Re: Complaint Number: NJ 00096671

Dear Mr. Terry:

Thank you for your courtesy and cooperation extended during the Complaint Investigation conducted on February 16, 2017 by a surveyor from the New Jersey Department of Health.

Enclosed is the statement of deficiencies; please reply to each deficiency on an item-by-item basis with your Plan of Correction (PoC).

The PoC must include:

1. How you will correct the specific findings cited for each deficiency.

2. What systemic changes will be implemented to ensure that each deficient practice does not recur.

3. How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur, i.e. what program will be put into place to monitor the continued effectiveness of the systemic changes. The plan must identify the individual responsible for monitoring, how and when the monitoring will be conducted, how long and how often monitoring will take place, what the goal is for compliance, and to whom the results will be reported.

4. The date on which each item addressed on the PoC will be corrected.

5. Do not reference and/or include attachments with your PoC.

6. Do not include names of individuals in the PoC. Use of titles is acceptable, such as, Administrator, Director of Nursing, Infection Control Practitioner, etc.

Please be advised that the PoC will not be accepted for review by this office and will be returned to you if it contains reference to and/or attachments and/or names of individuals.

All responses should be numbered to correspond with the number of your deficiency statements. Please sign and date the first page of the deficiency statement with your plan of correction. Return these forms to this office within ten (10) business days of receipt of this letter, to my attention. Any delay or lack of response may jeopardize the licensure of your facility.

Please be advised that some or all of the deficiencies cited in the enclosed survey report may be referred to the Office of Program Compliance ("OPC") for imposition of enforcement remedies, including civil penalties. OPC will advise you, at a later date and under separate cover, of any enforcement actions and your appeal rights.

Please do not hesitate to contact me, if you have any questions regarding the deficiencies at (609) 292-9900.

Sincerely,

Carrie Willis, RN

Carrie Willis, RN
Health Care Services Evaluator Nurse
Survey and Certification

Encl.